Diabetes Treatment using Updated Guidelines

Presented by:

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DISCLOSURES

MEDICAL SCIENCE LIAISON WITH ABBOTT DIABETES CARE (ADC) – MAY 2020 TO JUNE 2025

RETIRED FROM ADC WITH PENSION AND INDIVIDUAL ABBOTT STOCK REWARDED AT TERMINATION TO PRESENT

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Objective of presentation:

**Diabetes Treatment using updated Guidelines**

1. Participants will be able to identify the 17 key areas discussed in the ADA SOC guidelines and understand how to download the ADA Standard of Care App.

2. Participants will be able to utilize the ADA SOC guidelines to find evidence-based treatment modalities for diabetes and related comorbidities.

3. Participants will be able to utilize "the use of glucose lowering medications …" algorithm to provide evidence-based medication management for their patients with type 2 diabetes.

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ADA Standards of Care App
Get the Standards of Care App in the App Store for iOS or Google Play for Android for up-to-date recommendations and interactive tables and algorithms.
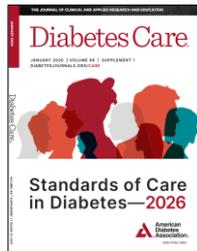
Standards of Care and Resources

American Diabetes Association.

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The American Diabetes Association's
Standards of Care in Diabetes—2026

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Standards of Care in Diabetes—2026

Intended to provide clinicians, patients, researchers, payers, and other interested individuals with the components of diabetes care, general treatment goals, and tools to evaluate the quality of care.
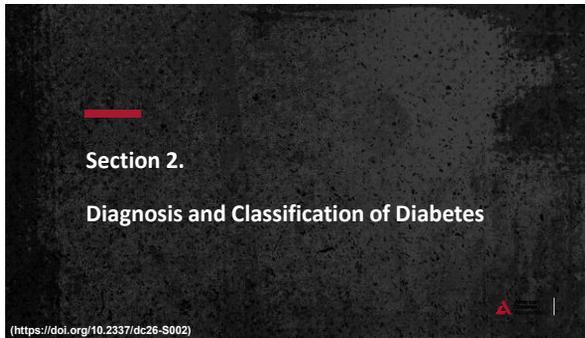
Diabetes Care

Standards of Care in Diabetes—2026

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Table of Contents

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Section 2.

Diagnosis and Classification of Diabetes

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2. Diagnosis and Classification of Diabetes

Table 2.1—Criteria for the diagnosis of diabetes in nonpregnant individuals

A1C ≥6.5% (≥48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.*

OR

FPG ≥126 mg/dL (≥7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.*

OR

2-h PG ≥200 mg/dL (≥11.1 mmol/L) during OGTT. The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*

OR

In an individual with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (≥11.1 mmol/L). Random is any time of the day without regard to time since previous meal.

DCCT, Diabetes Control and Complications Trial; FPG, fasting plasma glucose; OGTT, oral glucose tolerance test; NGSP, National Glycohemoglobin Standardization Program; WHO, World Health Organization; 2-h PG, 2-h plasma glucose. *In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal results from different tests which may be obtained at the same time (e.g., A1C and FPG), or the same test at two different time points.

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Table 2.2—Criteria defining prediabetes in nonpregnant individuals

A1C 5.7–6.4% (39–47 mmol/mol)
OR
FPG 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) (IFG)
OR
2-h PG during 75-g OGTT 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) (IGT)

For all three tests, risk is continuous, extending below the lower limit of the range and becoming disproportionately greater at the higher end of the range. FPG, fasting plasma glucose; IFG, impaired fasting glucose; IGT, impaired glucose tolerance; OGTT, oral glucose tolerance test; 2-h PG, 2-h plasma glucose.

Table 2.2
Diagnosis and Classification of Diabetes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S27-S49

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Classification (continued)

- Type 1 diabetes (due to autoimmune β-cell destruction, usually leading to absolute insulin deficiency, including latent autoimmune diabetes in adults)
- Type 2 diabetes (due to a nonautoimmune progressive loss of adequate β-cell insulin secretion, frequently on the background of insulin resistance)
- Specific types of diabetes due to other causes, e.g., monogenic diabetes syndromes, diseases of the exocrine pancreas, and drug- or chemical-induced diabetes
- Gestational diabetes mellitus (diabetes diagnosed in the second or third trimester of pregnancy that was not clearly overt diabetes prior to gestation or other types of diabetes occurring throughout pregnancy, such as type 1 diabetes)

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Table 2.5—Criteria for screening for diabetes or prediabetes in asymptomatic adults

1. Testing should be considered in adults with overweight or obesity (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in individuals of Asian ancestry) who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk race, ethnicity, and ancestry (e.g., African American, Latino, Native American, Asian American)
   - History of cardiovascular disease
   - Hypertension (≥130/80 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (<0.9 mmol/L) and/or triglyceride level >250 mg/dL (>2.8 mmol/L)
   - Individuals with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans, metabolic dysfunction–associated steatotic liver disease)
2. People with prediabetes (A1C ≥5.7% [≥39 mmol/mol], IGT, or IFG) should be tested yearly.
3. People who were diagnosed with GDM should have testing at least every 1–3 years.
4. For all other people, testing should begin at age 35 years.
5. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.
6. Individuals in other high-risk groups (e.g., people with HIV, exposure to high-risk medicines, evidence of periodontal disease, history of pancreatitis) should also be closely monitored

GDM, gestational diabetes mellitus; IFG, impaired fasting glucose; IGT, impaired glucose tolerance.

Table 2.5
Diagnosis and Classification of Diabetes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S27-S49

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Table 2.6—Risk-based screening for type 2 diabetes or prediabetes in asymptomatic children and adolescents in a clinical setting

Screening should be considered in youth* who have overweight (≥85th percentile) or obesity (≥95th percentile) and who have one or more additional risk factors:
- Maternal history of diabetes or GDM during the child's gestation
- Family history of type 2 diabetes in first- or second-degree relative
- High-risk race, ethnicity, and ancestry (see **Table 2.5**)
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome, large- or small-for-gestational-age birth weight)

GDM, gestational diabetes mellitus. *After the onset of puberty or after 10 years of age, whichever occurs earlier. If tests are normal, repeat testing at a minimum of 3-year intervals (or more frequently if BMI is increasing or risk factor profile is deteriorating) is recommended. Reports of type 2 diabetes before age 10 years exist, and this can be considered with numerous risk factors.

Table 2.6
Diagnosis and Classification of Diabetes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S27-S49

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Table 2.8—Screening for and diagnosis of GDM

One-step strategy
Perform a 75-g OGTT, with plasma glucose measurement when an individual is fasting and at 1 and 2 h, at 24–28 weeks of gestation in individuals not previously diagnosed with diabetes.
The OGTT should be performed in the morning after an overnight fast of at least 8 h.
The diagnosis of GDM is made when any of the following plasma glucose values are met or exceeded:
- Fasting: 92 mg/dL (5.1 mmol/L)
- 1 h: 180 mg/dL (10.0 mmol/L)
- 2 h: 153 mg/dL (8.5 mmol/L)

Two-step strategy
Step 1:
Perform a 50-g GLT (nonfasting), with plasma glucose measurement at 1 h, at 24–28 weeks of gestation in individuals not previously diagnosed with diabetes.
If the plasma glucose level measured 1 h after the load is ≥130, 135, or 140 mg/dL (7.2, 7.5, or 7.8 mmol/L, respectively),* proceed to a 100-g OGTT.
Step 2:
The 100-g OGTT should be performed when the individual is fasting.
The diagnosis of GDM is made when at least two>† of the following four plasma glucose levels (measured fasting and at 1, 2, and 3 h during OGTT) are met or exceeded (Carpenter-Coustan criteria [208]):
- Fasting: 95 mg/dL (5.3 mmol/L)
- 1 h: 180 mg/dL (10.0 mmol/L)
- 2 h: 155 mg/dL (8.6 mmol/L)
- 3 h: 140 mg/dL (7.8 mmol/L)

GDM, gestational diabetes mellitus; GLT, glucose load test; OGTT, oral glucose tolerance test. *American College of Obstetricians and Gynecologists (ACOG) recommends any of the commonly used thresholds of 130, 135, or 140 mg/dL for the 1-h 50-g GLT (223). †ACOG notes that one elevated value can be used for diagnosis (223).

Table 2.8
Diagnosis and Classification of Diabetes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S27-S49

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Section 3.

Prevention or Delay of Diabetes and Associated Comorbidities

(https://doi.org/10.2337/dc26-S003)

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Overall Recommendations

3.1 In people with prediabetes, monitor for the development of diabetes at least annually; modify frequency of testing based on individual risk assessment. **E**

3.2 In people with presymptomatic type 1 diabetes, monitor for disease progression using A1C approximately every 6 months and 75-g oral glucose tolerance test (i.e., fasting and 2-h plasma glucose) annually; modify frequency of monitoring and consider augmenting with other glycemic assessment tools such as continuous glucose monitoring metrics based on individual risk assessment based on age, number and type of autoantibodies, and glycemic metrics. **E**

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Lifestyle Behavior Change for Type 2 Diabetes Prevention

3.3 Refer adults with overweight or obesity at high risk of type 2 diabetes to a diabetes prevention program to achieve and maintain a weight reduction of at least 5–7% of initial body weight through a healthy reduced-calorie eating pattern and ≥150 min/week of moderate-intensity physical activity. **A**

3.4 Prescribe an evidence-based eating pattern (e.g., Mediterranean, low carbohydrate) to individuals with prediabetes to prevent type 2 diabetes. **B**

3.5 Offer diabetes prevention programs to adults at high risk for type 2 diabetes. **A** Diabetes prevention programs should be covered by third-party payors, and inconsistencies in access should be addressed. **E**

3.6 Based on individual preference, certified technology-assisted diabetes prevention programs through smartphones, web-based applications, and telehealth can be effective in preventing type 2 diabetes and should be considered. **B**

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Pharmacologic Interventions to Delay Type 2 Diabetes

3.7 Metformin for the prevention of type 2 diabetes should be considered in adults at high risk of type 2 diabetes, as typified by the Diabetes Prevention Program, especially those aged 25–59 years with BMI ≥35 kg/m², higher fasting plasma glucose (e.g., ≥110 mg/dL [≥6 mmol/L]), and higher A1C (e.g., ≥6.0% [≥42 mmol/mol]), and in individuals with prior gestational diabetes mellitus. **A**

3.8 Consider using metformin to prevent hyperglycemia in high-risk individuals treated with a phosphatidylinositol 3-kinase α (PI3Kα) inhibitor (e.g., alpelisib and inavolisib). **B**

3.9 Consider using metformin to prevent hyperglycemia in high-risk individuals treated with high-dose glucocorticoids. **B**

3.10 Consider periodic assessment of vitamin B12 levels in individuals receiving long-term metformin therapy, especially in those with anemia or peripheral neuropathy. **B**

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Prevention of Vascular Disease and Mortality

3.11 Prediabetes is associated with heightened cardiovascular risk; therefore, screening for and treatment of modifiable risk factors for cardiovascular disease are suggested. **B**

3.12 Statin therapy may increase the risk of type 2 diabetes in people at high risk of developing type 2 diabetes. In such individuals, glucose status should be monitored regularly and diabetes prevention approaches reinforced. It is not recommended that statins be avoided or discontinued for this adverse effect. **B**

3.13 In people with a history of stroke and evidence of insulin resistance and prediabetes, pioglitazone may be considered to lower the risk of stroke or myocardial infarction. However, this benefit needs to be balanced with the increased risk of weight gain, edema, and fractures. **A** Lower doses may mitigate the risk of adverse effects but may be less effective. **C**

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Person-Centered Care Goals

3.14 In adults with overweight or obesity at high risk of type 2 diabetes, care goals should include weight loss and maintenance, minimizing the progression of hyperglycemia, and attention to cardiovascular risk. **B**

3.15 Pharmacotherapy (e.g., for weight management, minimizing the progression of hyperglycemia, and cardiovascular risk reduction) should be considered to support person-centered care goals. **A**

3.16 More intensive preventive approaches should be considered in individuals who are at particularly high risk of progression to diabetes, including individuals with BMI ≥35 kg/m^2, those with higher glucose levels (e.g., fasting plasma glucose 110–125 mg/dL [6.1–6.9 mmol/L], 2-h post-challenge glucose 173–199 mg/dL [9.6–11.0 mmol/L], and A1C ≥6.0% [≥42 mmol/mol]), and individuals with a history of gestational diabetes mellitus. **A**

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Section 4.

Comprehensive Medical Evaluation and Assessment of Comorbidities

(https://doi.org/10.2337/dc26-S004)

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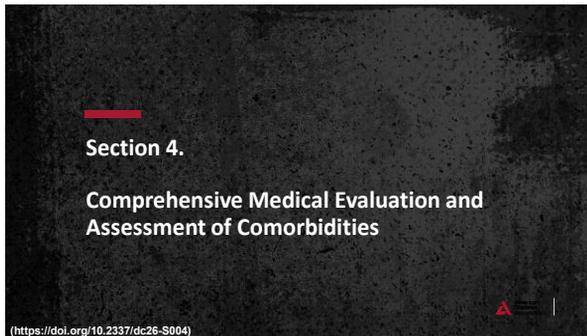
Decision cycle for person-centered glycemic management in type 2 diabetes

Figure 4.1
Comprehensive Medical Evaluation and Assessment of Comorbidities:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S61-S88

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Diagnostic algorithm for the prevention of cirrhosis in people with metabolic dysfunction–associated steatotic liver disease (MASLD)
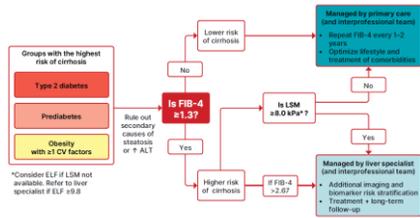
Figure 4.2—Diagnostic algorithm for risk stratification and the prevention of cirrhosis in individuals with metabolic dysfunction–associated steatotic liver disease (MASLD). CV, cardiovascular; ELF, enhanced liver fibrosis test; FIB-4, fibrosis-4 index; LSM, liver stiffness measurement, as measured by vibration-controlled transient elastography. *In the absence of LSM, consider ELF a diagnostic alternative. If ELF ≥9.8, an individual is at high risk of metabolic dysfunction-associated steatohepatitis with advanced liver fibrosis (≥F3–F4) and should be referred to a liver specialist.

Figure 4.2
Comprehensive Medical Evaluation and Assessment of Comorbidities:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S61-S88

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Section 5.

Facilitating Positive Behaviors and Well-being to Improve Health Outcomes

(https://doi.org/10.2337/dc26-S005)

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Diabetes Self-Management Education and Support

5.1 Advise all people with diabetes to participate in developmentally and culturally appropriate diabetes self-management education and support (DSMES) to facilitate informed decision-making, self-care behaviors, problem-solving, and active collaboration with the health care team. **A**

5.2 Provide DSMES at diagnosis, annually and/or when not meeting treatment goals, when complicating factors develop (e.g., medical, functional, and psychosocial), and when transitions in life and care occur. **E**

5.3 Assess clinical outcomes, health status, and well-being as key goals of DSMES on an individualized timeframe. **C**

5.4 Use behavioral strategies (e.g., motivational interviewing, goal setting, problem-solving) to support DSMES and engagement in behaviors known to optimize health-related quality of life and outcomes. **A**

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Medical Nutrition Therapy

5.10 Provide individualized medical nutrition therapy by referring people with prediabetes or diabetes to a registered dietitian nutritionist, preferably one who has comprehensive experience in diabetes care. **A**

5.11 Diabetes medical nutrition therapy can result in cost savings **B** and improved cardiometabolic outcomes **A** and should be reimbursed by insurance. **E**

5.12 Provide an overweight/obesity treatment plan based on their nutrition, physical activity, and behavioral health status for all people with overweight or obesity, aiming for at least 5–7% weight loss. **A**
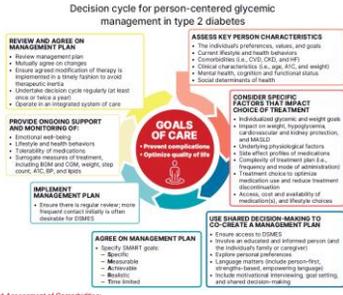
5.13 For diabetes prevention and management of people with prediabetes or diabetes, recommend individualized meal plans that keep nutrient quality, total calories, and metabolic goals in mind. **B**

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Table 5.2—Nutrition behaviors to encourage

- Vegetables—especially nonstarchy vegetables that are dark green, red, and orange in color; fresh, frozen, or low-sodium canned are all acceptable vegetable options.
- Legumes—dried beans, peas, and lentils.
- Fruits—especially whole fruit—fresh, frozen, or canned in own juice (or no added sugar) are all acceptable fruit options.
- Foods with at least 3 g of fiber per serving are generally considered higher fiber choices. Whole-grain foods—where culturally appropriate, whole-grain versions of commonly consumed foods, such as 100% whole-wheat breads or pastas and brown rice. When not culturally appropriate, focus more on portion control.
- Water should be the primary beverage of choice.
- For individuals who do not prefer plain water, no-calorie alternatives are the next best choice. Options include adding lemon, lime, berries, or cucumber slices to water; sparkling no-calorie water or flavored no-calorie waters; no-calorie carbonated beverages.
- Plant-based proteins can include legumes (e.g., soybeans, pinto beans, black beans, garbanzo beans, dried peas, and lentils), nuts, and seeds.
- Meats and poultry should be from fresh, frozen, or low-sodium canned and in lean forms (e.g., chicken breast and ground turkey).
- Heart-healthy wild-caught fatty fish such as salmon, tuna, sardines, and mackerel. Fresh, frozen, or low-sodium canned are all acceptable options.
- Use herbs (e.g., basil, fennel, mint, parsley, rosemary, and thyme) and spices (e.g., cinnamon, garam masala, ginger, pepper, and turmeric) to season foods instead of salt or salt-containing preparations.
- Incorporate onions, garlic, celery, carrots, and other vegetables as a base for preparing various homemade foods.
- Cook with vegetable oil (e.g., avocado, canola, and olive) in place of fats high in saturated fat (e.g., butter, coconut oil, lard, and shortening).
- Plan out meals for the week. Grocery shop using a list. Cook on a day off so there are ready-to-eat and ready-to-reheat homemade meals waiting in the fridge or freezer.
- Include family or roommates in meal preparation; share the responsibilities of grocery shopping and cooking and use time off for meal preparation in advance when possible.

Table 5.2
Facilitating Positive Heath Behaviors and Well-being to Improve Health Outcomes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S89-S131

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Physical Activity

5.34 Evaluate baseline physical activity and sedentary time for all people with diabetes and those at risk for diabetes. For people who do not meet activity guidelines, encourage an increase in physical activities above baseline with the goal of meeting activity guidelines. **B** Counsel that prolonged sitting should be interrupted at least every 30 min for blood glucose and other benefits. **C**

5.35 Counsel children and adolescents with type 1 diabetes **C** or type 2 diabetes **B** to engage in 60 min/day or more of moderate- or vigorous-intensity aerobic activity, with muscle-strengthening and bone-strengthening activities at least 3 days/week, and to limit the amount of time being spent sedentary, including recreational screen time. **C**

5.36 Counsel most adults with type 1 diabetes **C** and type 2 diabetes **B** to engage in 150 min or more of moderate-to vigorous-intensity aerobic activity per week, spread over at least 3 days/week, with no more than 2 consecutive days without activity. Shorter durations (minimum 75 min/week) of vigorous-intensity or interval training may be sufficient for more physically fit individuals.

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Smoking Cessation: Tobacco, e-Cigarettes, and Cannabis

5.40. Ask people with diabetes routinely about the use of tobacco or vape products. **A** Advise complete avoidance of tobacco and vaping. **A** For individuals who use these products, provide or refer for combination treatment consisting of tobacco and/or vape product(s) cessation counseling and pharmacologic therapy. **A**

5.41 Advise people with type 1 diabetes **C** and those with other forms of diabetes at risk for diabetic ketoacidosis not to use recreational cannabis in any form. **E**

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Psychosocial Care

5.42 Provide psychosocial care to all people with diabetes as part of routine medical care delivered by trained health care professionals using a collaborative, person-centered, culturally informed approach. **A**

5.43 Implement screening protocols for psychosocial concerns, preferably using age-appropriate standardized and validated tools. Screen at least annually or when there is a change in health status, treatment, or life circumstances. **C**

5.44 Refer to behavioral health professionals or other trained health care professionals, ideally those with experience in diabetes, for further assessment and treatment of psychosocial concerns as indicated. **B**

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Table 5.5—Situations that warrant referral of a person with diabetes to a qualified behavioral health professional for evaluation and treatment

- A positive screen on a validated screening tool for depressive symptoms, diabetes distress, anxiety, fear of hypoglycemia, suicidality, or cognitive impairment
- The presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- Intentional omission or underdosing of insulin or noninsulin medication to cause weight loss
- A serious mental illness is suspected
- In children and adolescents and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, failure to achieve expected developmental milestones, or significant distress
- Low engagement in diabetes self-management behaviors, including declining or impaired ability to perform diabetes self-management behaviors
- Before undergoing metabolic surgery and after surgery, if assessment reveals an ongoing need for adjustment support

Table 5.5
Facilitating Positive Heath Behaviors and Well-being to Improve Health Outcomes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S89-S131

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Diabetes Distress

5.45 Screen for diabetes distress at least annually in people with diabetes, caregivers, and family members, and repeat screening when treatment goals are not met, at transitional times, and/or in the presence of diabetes complications. Health care professionals should consider referral to a qualified behavioral health professional, ideally one with experience in diabetes, for further assessment and treatment if not adequately addressed during medical appointments. **B**

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Sleep Health

5.56 Screen for sleep health in people with prediabetes, diabetes, and those at risk for diabetes, including sleep disorders and diabetes-related sleep disruptions. Refer to sleep medicine specialists and/or qualified behavioral health professionals or diabetes care team as indicated. **B**

5.57 Counsel people with diabetes to practice sleep-promoting routines and habits. **A**

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Slide 43

Importance of 24-hour physical behaviors for type 2 diabetes

Figure 5.2
Facilitating Positive Heath Behaviors and Well-being to Improve Health Outcomes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S89-S131

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Section 6.

Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises

(https://doi.org/10.2337/dc26-S006)

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Slide 45

Glycemic Assessment

6.1 Assess glycemic status by A1C **A** and/or continuous glucose monitoring (CGM) metrics such as time in range, time above range, and time below range. **B** Fructosamine or CGM can be used for glycemic monitoring when an alternative to A1C is required. **B**

6.2 Assess glycemic status at least two times a year, and more frequently (e.g., every 3 months) for individuals not meeting glycemic goals or with recent treatment changes, frequent or severe hypoglycemia or hyperglycemia, or changes in health status, or during periods of rapid growth and development in children and adolescents. **E**

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Table 6.1—Equivalent A1C levels and estimated average glucose (eAG)

A1C (%)	A1C (mmol/mol)	eAG mg/dL*	eAG mmol/L
5	31	97 (76–120)	5.4 (4.2–6.7)
6	42	126 (100–152)	7.0 (5.5–8.5)
7	53	154 (123–185)	8.6 (6.8–10.3)
8	64	183 (147–217)	10.2 (8.1–12.1)
9	75	212 (170–249)	11.8 (9.4–13.9)
10	86	240 (193–282)	13.4 (10.7–15.7)
11	97	269 (217–314)	14.9 (12.0–17.5)
12	108	298 (240–347)	16.5 (13.3–19.3)

Data in parentheses are 95% CI. A calculator for converting A1C results into eAG, in either mg/dL or mmol/L, is available at professional.diabetes.org/eAG. *These estimates are based on ADAG data of ~2,700 glucose measurements over 3 months per A1C measurement in 507 adults with type 1, type 2, or no diabetes. The correlation between A1C and average glucose was 0.92 (19,20). Adapted from Nathan et al. (19).

Table 6.1
Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S132-S149

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Table 6.3—Summary of glycemic goals for many nonpregnant adults with diabetes

A1C	<7.0% (<53 mmol/mol)*†
Preprandial capillary plasma glucose	80–130 mg/dL* (4.4–7.2 mmol/L)
Peak postprandial capillary plasma glucose‡	<180 mg/dL* (<10.0 mmol/L)

*More or less stringent glycemic goals may be appropriate for certain individuals. †CGM may be used to assess glycemic status as noted in Recommendations 6.3b and 6.3c. Goals should be individualized based on duration of diabetes, age and life expectancy, comorbid conditions, known cardiovascular disease or advanced microvascular complications, impaired awareness of hypoglycemia, and individual considerations (per **Fig. 6.1**). ‡Postprandial glucose may warrant attention if A1C goals are not met despite reaching preprandial glucose goals. Postprandial glucose measurements should be made 1–2 h after the beginning of the meal, which is generally the timing for peak levels in people with diabetes.

Table 6.3
Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S132-S149

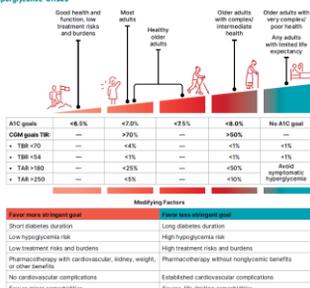American Diabetes Association. 47

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Figure 6.1
Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S132-S149

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Hypoglycemia Assessment, Prevention, and Treatment

6.10 Review history of hypoglycemia at every clinical encounter for all individuals at risk for hypoglycemia, and evaluate hypoglycemic events as indicated. **C**

6.11 Screen individuals at risk for hypoglycemia for impaired hypoglycemia awareness at least annually and when clinically appropriate. **E** Refer to a trained health care professional for evidence-based intervention to improve hypoglycemia awareness. **A**

6.12 Screen individuals at high risk for hypoglycemia or with severe and/or frequent hypoglycemia for fear of hypoglycemia at least annually and when clinically appropriate. **E** Refer to a trained health care professional for evidence-based intervention. **A**

6.13 Consider an individual's risk for hypoglycemia (see **Table 6.5**) when selecting diabetes medications and glycemic goals. **B**

6.14 Use of CGM is beneficial and recommended for individuals at high risk for hypoglycemia. **A**

6.15 Glucose is the preferred treatment for the conscious individual with glucose <70 mg/dL (<3.9 mmol/L), although any form of carbohydrate that contains glucose may be used. Avoid using foods or beverages high in fat and/or protein for initial treatment of hypoglycemia. Fifteen minutes after initial treatment, repeat the treatment if hypoglycemia persists. **B**

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Table 6.4—Classification of hypoglycemia

	Glycemic criteria/description
Level 1	Glucose <70 mg/dL (<3.9 mmol/L) and ≥54 mg/dL (≥3.0 mmol/L)
Level 2	Glucose <54 mg/dL (<3.0 mmol/L)
Level 3	A severe event characterized by altered mental and/or physical status requiring assistance for treatment of hypoglycemia, irrespective of glucose level

Adapted from Agiostratidou et al. (71).

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Hyperglycemic Crises: Diagnosis, Management, and Prevention

6.21 Review history of hyperglycemic crises (i.e., diabetic ketoacidosis and hyperglycemic hyperosmolar state) at every clinical encounter for all individuals with diabetes at risk for these events. **C**

6.22 Provide structured education on the recognition, prevention, and management of hyperglycemic crisis to all individuals with type 1 diabetes, those with type 2 diabetes who have experienced these events, and people at high risk for these events. **B**

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Table 6.8—Risk factors for hyperglycemic crises

Type 1 diabetes/absolute insulin deficiency
Younger age
Prior history of hyperglycemic crises
Prior history of hypoglycemic crises
Presence of other diabetes complications
Presence of other chronic health conditions (particularly in people with type 2 diabetes)
Presence of behavioral health conditions (e.g., depression, bipolar disorder, and eating disorders)
Alcohol and/or substance use
High A1C level
Insulin rationing
SGLT2 (SGLT1/2) inhibitor use
Social determinants of health

SGLT, sodium–glucose cotransporter. Data are from McCoy et al. (194), Gibb et al. (195), Randall et al. (196), Thomas et al. (197), and Borden et al. (198).

Table 6.8
Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S132-S149

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Section 7.

Diabetes Technology

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Continuous Glucose Monitoring Devices

7.15 Use of CGM is recommended at diabetes onset and anytime thereafter for children, adolescents, and adults with diabetes who are on insulin therapy, **A** on noninsulin therapies that can cause hypoglycemia, **C** and on any diabetes treatment where CGM helps in management. **C** The specific CGM device and method for use should be made based on the individual's circumstances, preferences, and needs. **E**

7.16 In people with diabetes on insulin therapy, CGM devices should be used as close to daily as possible for maximal benefit. **A** People with diabetes should have uninterrupted access to their supplies to minimize gaps in CGM. **A**

7.17 During pregnancy for individuals with type 1 diabetes, CGM can help achieve glycemic goals (e.g., time in range and time above range) A and A1C goal **B** and may be beneficial for other types of diabetes in pregnancy. **E** See section 15, "Management of Diabetes in Pregnancy," for more detail regarding use of technology in pregnancy.

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Continuous Glucose Monitoring Devices (continued)

7.18 In circumstances when consistent use of CGM is not feasible, consider periodic use of personal or professional CGM to adjust medication and/or lifestyle. **C**

7.19 Skin reactions, either due to irritation or allergy, should be assessed and addressed to aid in successful use of devices. **E**

7.20 People who wear CGM devices should be educated on potential interfering substances and other factors that may affect accuracy. **C**

American Diabetes Association. 55

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Table 7.3—Continuous glucose monitoring devices

Type of device	Brand*	Availability	Alarms
rtCGM	Libre 2 Plus/Libre 3 Plus	Prescription	Yes
	Dexcom G6/G7	Prescription	Yes
	Eversense 365	Prescription	Yes
	Guardian 4	Prescription	Yes
	Simplera	Prescription	Yes
OTC-CGM	Dexcom Stelo	OTC	No
	Abbott Lingo	OTC	No
Professional CGM	Abbott Freestyle Libre Pro	In office	No
	Dexcom G6 Pro	In office	No

CGM, continuous glucose monitoring; isCGM, intermittently scanned CGM; OTC, over the counter; rtCGM, real-time CGM. *Generic names not available.

Table 7.3
Diabetes Technology:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S150-S165

American Diabetes Association. 56

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Insulin Delivery (syringes and pens)

7.21 For people with insulin-requiring diabetes on MDI, insulin pens are preferred in most cases. Still, insulin syringes may be used for insulin delivery considering individual and caregiver preference, insulin type, availability in vials, dosing therapy, cost, and self management capabilities. **C**

7.22 Insulin pens or insulin injection aids are recommended for people with dexterity issues or vision impairment or when decided by shared decision making to facilitate the accurate dosing and administration of insulin. **C**

7.23 Offer connected insulin pens for people with diabetes taking multiple daily insulin injections when appropriate. **B**

7.24 FDA-approved insulin dose calculators/decision support systems may be helpful for calculating insulin doses. **B**

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Insulin Delivery (Pumps and Automated Delivery Systems)

7.25a AID systems are the preferred insulin delivery method over multiple daily injections (MDI), CSII, and sensor- augmented pump in people with type 1 diabetes, **A** adults with type 2 diabetes, **A** children and adolescents with type 2 diabetes, **E** and other forms of insulin-deficient diabetes. **B–E** Choice of an AID system should be made based on the individual's circumstances, preferences, and needs. **E**

7.25b Consider AID systems for select people with type 2 diabetes treated with basal insulin not achieving individualized glycemic goals. **B** Choice of an AID system should be made based on the individual's circumstances, preferences, and needs. **E**

7.26 Individuals with diabetes who have been using CSII and/or AID should have continued access across third party payors. **E**

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Inpatient Care

7.29 In people with diabetes wearing personal CGM, the use of CGM should be continued when clinically appropriate during hospitalization, with confirmatory point-of-care glucose measurements for insulin dosing and hypoglycemia assessment and treatment under an institutional protocol. **B**

7.30 Continue use of insulin pump or AID in people with diabetes who are hospitalized when clinically appropriate. This is contingent upon availability of necessary supplies, resources, training, ongoing competency assessments, and implementation of institutional diabetes technology protocols. **C**

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Section 8.

Obesity and Weight Management for the Prevention and Treatment of Diabetes

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8. Obesity and Weight Management for the Prevention and Treatment of Diabetes

Assessment and Monitoring of the Individual with Overweight or Obesity

8.1 Use person-centered, nonjudgmental language that fosters collaboration between individuals and health care professionals, including person-first language (e.g., "person with obesity" rather than "obese person" and "person with diabetes" rather than "diabetic person"). **E**

8.2a Screen for overweight and obesity using BMI annually. To confirm excess adiposity, additional assessments of body fat using anthropometric assessments (e.g., waist-to-hip ratio) or direct measurements (e.g., dual-energy X-ray absorptiometry, bioelectrical impedance analysis) could be considered where available/feasible. **E**

8.2b Monitor obesity-related anthropometric measurements at least annually to inform treatment considerations. During active weight management treatment, increase monitoring to at least every 3 months. **E**

8.3 Accommodations should be made to provide privacy during anthropometric measurements. **E**

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8. Obesity and Weight Management for the Prevention and Treatment of Diabetes

Assessment and Monitoring of the Individual with Overweight or Obesity (continued)

8.4 In people with type 2 diabetes and overweight or obesity, weight management should represent a primary goal of treatment along with glycemic management. **A**

8.5 Provide weight management treatment, aiming for any magnitude of weight loss. Weight loss of 5–7% of baseline weight improves glycemia and other intermediate cardiovascular risk factors. **A** Sustained loss of >10% of body weight usually confers greater benefits, including disease-modifying effects and possible remission of type 2 diabetes **A** and may improve long-term cardiovascular outcomes and mortality. **B**

8.6 Individualize initial treatment approaches for obesity (i.e., lifestyle and nutritional therapy, pharmacologic therapy, or metabolic surgery) **A** based on the person's medical history, life circumstances, and preferences. **C** Consider combining treatment approaches if appropriate. **C**

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Section 9.

Pharmacologic Approaches to Glycemic Treatment

(https://doi.org/10.2337/dc26-S009)

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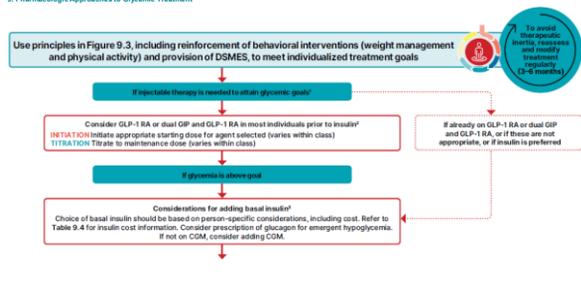**9. Pharmacologic Approaches to Glycemic Treatment**

Figure 9.4
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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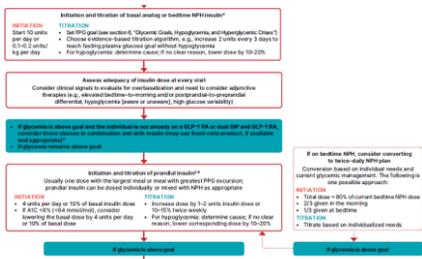**9. Pharmacologic Approaches to Glycemic Treatment**

Figure 9.4 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment
Table 9.2—Features of medications for lowering glucose in type 2 diabetes

Table 9.2
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment

Table 9.2—Continued

Medication (route of administration)	Glucose-lowering efficacy[a]	Hypoglycemia risk	Weight effects[a]	CV effects		Kidney effects			Clinical considerations and adverse effects
				Effect on MACE	Effect on HF	Progression of CKD	Dosing/use considerations*	MASH effects	
GLP-1 RAs (SQ; oral where available to oral formulation)	High to very high	No	Loss (intermediate to very high)	Benefit: dulaglutide, liraglutide, semaglutide (SQ) and oral	Benefit: semaglutide (SQ)	Benefit for kidney end points in CKD (semaglutide, dulaglutide, liraglutide, semaglutide (SQ))	• See labels of individual agents for dosage considerations for kidney function • No dose adjustment for dulaglutide, liraglutide, or semaglutide • Monitor kidney function when initiating or escalating doses in individuals with kidney impairment reporting severe adverse GI reactions	Benefit: semaglutide (SQ)	• Thyroid C-cell tumors identified in rodents; human relevance not determined • Provide guidance on discontinuation prior to surgical procedures to mitigate potential for pulmonary aspiration with general anesthesia or deep sedation • Pancreatitis: acute pancreatitis has been reported, but causality has not been established; do not initiate if history of pancreatitis is suspected, and discontinue if pancreatitis is suspected • Biliary disease: evaluate for gallbladder disease if cholelithiasis or cholecystitis is suspected; avoid use in case of diabetic retinopathy...
			Neutral: exenatide once weekly, lixisenatide	Benefit: demonstrated benefit for progression of CKD for semaglutide (SQ)			
Dual GIP and GLP-1 RA (SQ)	Very high	No	Loss (very high)	Under investigation	Benefit: tirzepatide	Potential benefit	• See labels of individual agents for dosage considerations for kidney function • No dose adjustment • Monitor kidney function when initiating or escalating doses in individuals with kidney impairment reporting severe adverse GI reactions	Potential benefit	• Thyroid C-cell tumors identified in rodents; human relevance not determined • Diabetic retinopathy: close monitoring of retinopathy in those at high risk • Pancreatitis ... (≥35 years) • Nonarteritic anterior ischemic optic neuropathy (NAION) reported (rare incidence) monitor for NAION during eye examinations • Impact on drug absorption: orally administered drugs absorption may be impaired during slow titration (delaying and oral contraceptives) • GI side effects: counsel on potential for GI side effects; provide guidance on dietary modifications to mitigate GI side effects (reduction in meal size, mindful eating practices [e.g., stop eating...

Table 9.2 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment

Table 9.2—Continued

Medication (route of administration)	Glucose-lowering efficacy[a]	Hypoglycemia risk	Weight effects[a]	CV effects		Kidney effects			Clinical considerations and adverse effects
				Effect on MACE	Effect on HF	Progression of CKD	Dosing/use considerations*	MASH effects	
									...urea fail, decreasing intake of high-fat or spicy food); consider slower dose titration for those experiencing GI challenges; do not recommend for individuals with gastroparesis
DPP-4 inhibitors (oral)	Intermediate	No	Neutral	Neutral	Neutral (potential risk: saxagliptin)	Neutral	• Dose adjustment required based on kidney function (sitagliptin, saxagliptin, alogliptin) • No dose adjustment required for linagliptin	Unknown	• Pancreatitis has been reported but causality has not been established; discontinue if pancreatitis is suspected • Postmarketing concerns about joint pain (consider discontinuing if debilitating and other treatment options are feasible) and bullous pemphigoid (discontinue if suspected; resolvable upon discontinuation
Thiazolidinediones (oral)	High	No	Gain	Potential benefit	Increased risk	Neutral	• No dose adjustment required • Generally not recommended in setting of kidney impairment due to potential for fluid retention	Potential benefit	• Increased risk of HF and fluid retention; do not use in setting of HF • Risk of bone fractures • Bladder cancer: do not use in individuals with active bladder cancer and use caution in those with prior history of bladder cancer; association may be related to higher cumulative exposure (e.g., longer duration, higher doses)
Sulfonylureas (2nd generation) (oral)	High	Yes	Gain	Neutral	Neutral	Neutral	• Glyburide: generally not recommended in CKD • Glipizide and glimepiride: initiate conservatively to avoid hypoglycemia	Unknown	• FDA Special Warning on increased risk of CV mortality based on studies of an older sulfonylurea (tolbutamide); glimepiride shown to be CV safe (see text) • Use with caution in individuals at risk for hypoglycemia, particularly if in combination with insulin

Table 9.2 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment

Table 9.2—Continued

Medication (route of administration)	Glucose-lowering efficacy[a]	Hypoglycemia risk	Weight effects[a]	CV effects		Kidney effects			Clinical considerations and adverse effects
				Effect on MACE	Effect on HF	Progression of CKD	Dosing/use considerations*	MASH effects	
Insulin (human) (SQ; regular insulin also available as inhaled formulation) Insulin (analog) (SQ)	High to very high	Yes	Gain	Neutral	Neutral	Neutral	• Lower insulin doses required with a decrease in eGFR; titrate per clinical response	Unknown	• Injection site reactions • Higher risk of hypoglycemia with human insulin (NPH or premixed formulations) vs. analogs • Risk of hypoglycemia and duration of activity increases with severity of impaired kidney function • Refer to device-specific instructions for insulins compatible with different delivery systems (i.e., pumps, connected insulin pens, insulin patches)

CKD, chronic kidney disease; CV, cardiovascular; DKA, diabetic ketoacidosis; DPP-4, dipeptidyl peptidase 4; eGFR, estimated glomerular filtration rate; FDA, U.S. Food and Drug Administration; GI, gastrointestinal; GIP, glucose-dependent insulinotropic polypeptide; GLP-1 RA, glucagon-like peptide 1 receptor agonist; HF, heart failure; MACE, major adverse cardiovascular events; MASH, metabolic dysfunction-associated steatohepatitis; SGLT2, sodium-glucose cotransporter 2; SQ, subcutaneous; T2D, type 2 diabetes. *For agent-specific dosing recommendations, please refer to manufacturers' prescribing information. [a]Tsapas et al. (107). [b]Tsapas et al. (317). Adapted from Davies et al. (90).

Table 9.2 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment

Use principles in Figure 9.3, including reinforcement of behavioral interventions (weight management and physical activity) and provision of DSMES, to meet individualized treatment goals

To avoid therapeutic inertia, reassess and modify treatment regularly (3–6 months)

If injectable therapy is needed to attain glycemic goals[1]

Consider GLP-1 RA or dual GIP and GLP-1 RA in most individuals prior to insulin[2]
INITIATION Initiate appropriate starting dose for agent selected (varies within class)
TITRATION Titrate to maintenance dose (varies within class)

If already on GLP-1 RA or dual GIP and GLP-1 RA, or if these are not appropriate, or if insulin is preferred

If glycemia is above goal

Considerations for adding basal insulin[3]
Choice of basal insulin should be based on person-specific considerations, including cost. Refer to Table 9.4 for insulin cost information. Consider prescription of glucagon for emergent hypoglycemia. If not on CGM, consider adding CGM.

Figure 9.5
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment

Initiation and titration of basal analog or bedtime NPH insulin[4]
INITIATION Start 10 units per day or 0.1–0.2 units/kg per day
TITRATION
• Set FPG goal (see section 6, "Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises")
• Choose evidence-based titration algorithm, e.g., increase 2 units every 3 days to reach fasting plasma glucose goal without hypoglycemia
• For hypoglycemia: determine cause; if no clear reason, lower dose by 10–20%

Assess adequacy of insulin dose at every visit
Consider clinical signals to evaluate for overbasalization and need to consider adjunctive therapies (e.g., elevated bedtime-to-morning and/or postprandial-to-preprandial differential, hypoglycemia [aware or unaware], high glucose variability)

• If glycemia is above goal and the individual is not already on a GLP-1 RA or dual GIP and GLP-1 RA, consider these classes in combination and with insulin (may use fixed-ratio product, if available and appropriate)[5]
• If glycemia remains above goal

Initiation and titration of prandial insulin[5,6]
Usually one dose with the largest meal or meal with greatest PPG excursion; prandial insulin can be dosed individually or mixed with NPH as appropriate
INITIATION
• 4 units per day or 10% of basal insulin dose
• If A1C <8% (<64 mmol/mol), consider lowering the basal dose by 4 units per day or 10% of basal dose
TITRATION
• Increase dose by 1–2 units insulin dose or 10–15% twice weekly
• For hypoglycemia: determine cause; if no clear reason, lower corresponding dose by 10–20%

If on bedtime NPH, consider converting to twice-daily NPH plan
Conversion based on individual needs and current glycemic management. The following is one possible approach:
INITIATION
• Total dose = 80% of current bedtime NPH dose
• 2/3 given in the morning
• 1/3 given at bedtime
TITRATION
• Titrate based on individualized needs

If glycemia is above goal

If glycemia is above goal

Figure 9.5 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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9. Pharmacologic Approaches to Glycemic Treatment

Stepwise doses of prandial insulin (i.e., two, then three additional injections)

Proceed to full basal-bolus plan (i.e., basal insulin and prandial insulin with each meal)

Consider self-mixed/split insulin plan
Can adjust NPH and short/rapid-acting insulins separately
INITIATION
• Total NPH dose = 80% of current NPH dose at the same total
• 2/3 given before breakfast
• 1/3 given before dinner
• Add 4 units of short/rapid-acting insulin to each injection or 10% of reduced NPH dose
TITRATION
• Titrate each component of the plan based on individualized needs

Consider twice-daily premixed insulin plan
INITIATION
• Usually unit per unit at the same total insulin dose, but may require adjustment to individual needs
TITRATION
• Titrate based on individualized needs

1. Consider insulin as the first injectable if symptoms of hyperglycemia are present, when A1C or blood glucose levels are very high (i.e., A1C >10% [>86 mmol/mol] or blood glucose ≥300 mg/dL [≥16.7 mmol/L]), or when a diagnosis of type 1 diabetes is a possibility.
2. When selecting GLP-1 RAs, consider individual preference, glycemic lowering, weight-lowering effect, and frequency of injection. If CVD is present, consider GLP-1 RA with proven CVD benefit; oral or injectable GLP-1 RAs are appropriate.
3. For people on GLP-1 RA and basal insulin combination, consider use of a fixed-ratio combination product (iDegLira or iGlarLixi).
4. Consider switching from evening NPH to a basal analog if the individual develops hypoglycemia and/or frequently forgets to administer NPH in the evening and would be better managed with a morning dose of a long-acting basal insulin. Consider dosing NPH in the morning for steroid-induced hyperglycemia.
5. Prandial insulin options include injectable rapid- and ultra-rapid-acting analog insulins, injectable short-acting human insulin, or inhaled human insulin.
6. If adding prandial insulin to NPH, consider initiation of a self-mixed or premixed insulin plan to decrease the number of injections required.

Figure 9.5—Intensifying to injectable therapies in type 2 diabetes. CGM, continuous glucose monitoring; DSMES, diabetes self-management education and support; FPG, fasting plasma glucose; GLP-1 RA, glucagon-like peptide 1 receptor agonist; GIP, glucose-dependent insulinotropic polypeptide; PPG, postprandial glucose. Adapted from Davies et al. (318).

Figure 9.5 (continued)
Pharmacologic Approaches to Glycemic Treatment:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S183-215

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Additional Recommendations For All Individuals with Diabetes

9.24 Include healthy behaviors, diabetes self-management education and support, avoidance of therapeutic inertia, and social determinants of health as essential components of the glucose-lowering management of diabetes. **A**

9.25 Use of continuous glucose monitoring (CGM) is recommended at diabetes onset and anytime thereafter for adults with diabetes who are on insulin therapy, **A** on noninsulin therapies that can cause hypoglycemia, **B** and on any diabetes treatment where CGM aids in management. **B** The choice of CGM device and method for use should be made based on the individual's circumstances, preferences, and needs. **B**

9.26 Monitor for signs of overbasalization during insulin therapy, such as significant bedtime-to-morning or postprandial-to-preprandial glucose differential, occurrences of hypoglycemia (aware or unaware), and high glycemic variability. When overbasalization is suspected, a thorough reevaluation should occur promptly to further tailor therapy to the individual's needs. **E**

9.27 Automated insulin delivery systems should be offered to all adults with type 1 and 2 diabetes on insulin depending on the person's or caregiver's needs and preferences. **A**
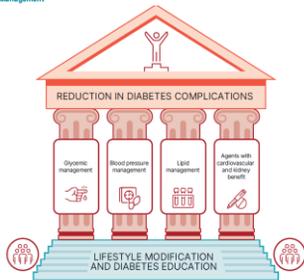
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Section 10.

Cardiovascular Disease and Risk Management

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Figure 10.1
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 Diabetes Care 2026;49(Suppl. 1):S216–S245

Figure 10.1—Multifactorial approach to reduction in risk of diabetes complications.

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Hypertension and Blood Pressure Management – Screening and Diagnosis

10.1 Blood pressure should be measured at every routine clinical visit, or at least every 6 months. Individuals found to have elevated blood pressure without a diagnosis of hypertension (systolic blood pressure 120–129 mmHg and diastolic blood pressure <80 mmHg) should have blood pressure confirmed using multiple readings, including measurements on a separate day, to diagnose hypertension. **A** Hypertension is defined as a systolic blood pressure ≥130 mmHg or a diastolic blood pressure ≥80 mmHg based on an average of two or more measurements obtained on two or more occasions. **A** Individuals with blood pressure ≥180/110 mmHg and cardiovascular disease could be diagnosed with hypertension at a single visit. **E**

10.2 Counsel all people with hypertension and diabetes to monitor their blood pressure at home after appropriate education. **A**

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Lipid management for primary prevention of atherosclerotic cardiovascular disease events in people with diabetes in addition to healthy behavior modification
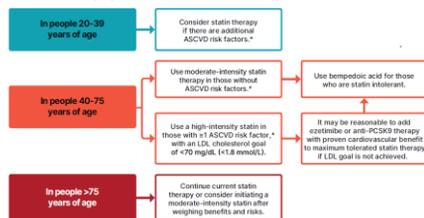
Figure 10.3—Recommendations for primary prevention of atherosclerotic cardiovascular disease (ASCVD) in people with diabetes using cholesterol-lowering therapy. *ASCVD risk factors include older age, hypertension, dyslipidemia, smoking, chronic kidney disease, or obesity. Adapted from "Standards of Care in Diabetes—2024 Abridged for Primary Care Professionals" (815).

Figure 10.3
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 Diabetes Care 2026;49(Suppl. 1):S216-S245

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Table 10.1—High-intensity and moderate-intensity statin therapy

High-intensity statin therapy (lowers LDL cholesterol by ≥50%)	Moderate-intensity statin therapy (lowers LDL cholesterol by 30–49%)
Atorvastatin 40–80 mg	Atorvastatin 10–20 mg
Rosuvastatin 20–40 mg	Rosuvastatin 5–10 mg
	Simvastatin 20–40 mg
	Pravastatin 40–80 mg
	Lovastatin 40 mg
	Fluvastatin XL 80 mg
	Pitavastatin 1–4 mg

Once-daily dosing. XL, extended release.

Table 10.1
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 Diabetes Care 2026;49(Suppl. 1):S216-S245

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10. Cardiovascular Disease and Risk Management
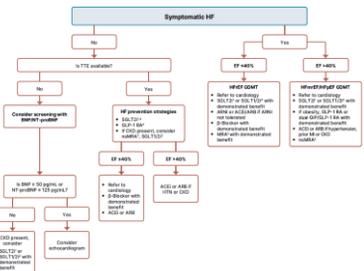
Figure 10.5
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 Diabetes Care 2026;49(Suppl. 1):S216–S245

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10. Cardiovascular Disease and Risk Management
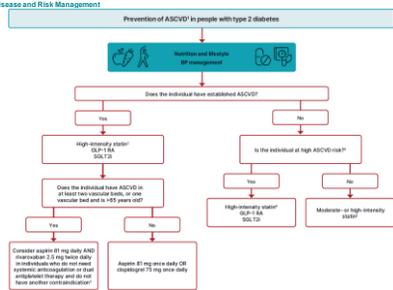
Figure 10.6
Cardiovascular Disease and Risk Management:
Standards of Care in Diabetes - 2026 Diabetes Care 2026;49(Suppl. 1):S216–S245

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Section 11.

Chronic Kidney Disease and Risk Management

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11. Chronic Kidney Disease and Risk Management

Figure 11.1
Chronic Kidney Disease and Risk Management:
Standards of Care in Diabetes – 2026 Diabetes Care 2026;49(Suppl. 1):S246–S260

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11. Chronic Kidney Disease and Risk Management
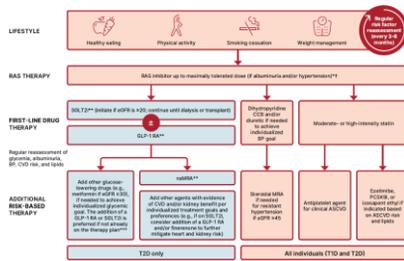
Figure 11.2
Chronic Kidney Disease and Risk Management:
Standards of Care in Diabetes – 2026 Diabetes Care 2026;49(Suppl. 1):S246–S260

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11. Chronic Kidney Disease and Risk Management

Table 11.3—Interventions that lower albuminuria

- Blood glucose management
- Blood pressure management
- Treatment with ACE inhibitors or ARBs
- Smoking cessation
- Weight loss
- Changes in eating patterns (decreased salt intake and/or protein intake)
- Physical activity
- Treatment with SGLT2 inhibitors, MRAs, or GLP-1 RAs

ARB, angiotensin receptor blocker; GLP-1 RA, glucagon-like peptide 1 receptor agonist; MRA, mineralocorticoid receptor antagonist; SGLT2, sodium–glucose cotransporter 2.

Table 11.3
Chronic Kidney Disease and Risk Management:
Standards of Care in Diabetes – 2026 Diabetes Care 2026;49(Suppl. 1):S246–S260

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Section 12.

Retinopathy, Neuropathy, and Foot Care
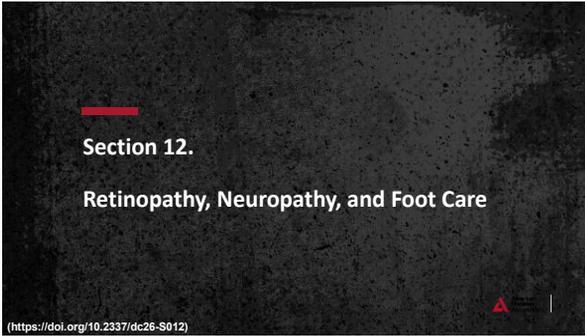
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12. Retinopathy, Neuropathy, and Foot Care

Diabetic Retinopathy - Screening

12.3 Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist 5 years after the onset of diabetes. **B**

12.4 People with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis. **B**

12.5 If there is no evidence of retinopathy from one or more annual eye exams and glycemic indicators are within the goal range, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight threatening, then examinations by an ophthalmologist will be required more frequently. **B**

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12. Retinopathy, Neuropathy, and Foot Care

Diabetic Retinopathy – Screening (continued)

12.6 Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration– approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated. **B**

12.7 Counsel individuals of childbearing potential with preexisting type 1 or type 2 diabetes who are planning pregnancy or who are pregnant on the risk of development and/or progression of diabetic retinopathy. **B**

12.8 Individuals with preexisting type 1 or type 2 diabetes should receive an eye exam before pregnancy as well as in the first trimester and may need to be monitored every trimester and for 1 year postpartum as indicated by the degree of retinopathy. **B**

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Visual Rehabilitation

12.15 People who experience diabetes-related vision loss should be counseled on the availability and scope of vision rehabilitation care and provided, or referred for, a comprehensive evaluation of their visual impairment by a practitioner experienced in vision rehabilitation. **E**

12.16 People with diabetes-related vision loss should receive educational materials and resources for eye care support in addition to self-management education (e.g., glycemic management and hypoglycemia awareness). **E**

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Neuropathy – Screening

12.17 All people with diabetes should be assessed for diabetic peripheral neuropathy starting at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes and at least annually thereafter. **B**

12.18 Assessment for distal symmetric polyneuropathy should include a careful history and assessment of either temperature or pinprick sensation (small-fiber function) and vibration sensation using a 128-Hz tuning fork (large-fiber function). All people with diabetes should have annual 10-g monofilament testing to identify feet at risk for ulceration and amputation. **B**

12.19 Symptoms and signs of autonomic neuropathy should be assessed in people with diabetes starting at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes, and at least annually thereafter, and with evidence of other microvascular complications, particularly kidney disease and diabetic peripheral neuropathy. Screening can include asking about orthostatic dizziness, syncope, early satiety, erectile dysfunction, changes in sweating patterns, or dry cracked skin in the extremities. Signs of autonomic neuropathy include orthostatic hypotension, a resting tachycardia, or evidence of peripheral dryness or cracking of skin. **E**

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Neuropathy – Treatment

12.20 Optimize glucose management to prevent or delay the development of neuropathy in people with type 1 diabetes **A** and to slow the progression of neuropathy in people with type 2 diabetes. **C** Optimize weight, blood pressure, and serum lipid management to reduce the risk or slow the progression of diabetic neuropathy. **B**

12.21 Assess and treat pain related to diabetic peripheral neuropathy **B** and symptoms of autonomic neuropathy to improve quality of life. **E**

12.22 Gabapentinoids, serotonin - norepinephrine reuptake inhibitors, tricyclic antidepressants, and sodium channel blockers are recommended as initial pharmacologic treatments for neuropathic pain in diabetes. **A** Combinations of these medications can provide additional relief of neuropathic pain. **A** Opioids, including tramadol and tapentadol, should not be used for neuropathic pain treatment in diabetes given the potential for adverse events except in rare circumstances. **B**

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Foot Care

12.23 Perform a comprehensive foot evaluation at least annually to identify risk factors for ulcers and amputations. **A**

12.24 The examination should include inspection of the skin, assessment of foot deformities, neurological assessment (10-g monofilament testing or Ipswich touch test with at least one additional assessment: pinprick, temperature, or vibration), and vascular assessment, including pulses in the legs and feet. **B**

12.25 Individuals with evidence of sensory loss or prior ulceration or amputation should have their feet inspected at every visit. **A**

12.26 Obtain a prior history of ulceration, amputation, Charcot foot, angioplasty or vascular surgery, cigarette smoking, retinopathy, and renal disease and assess current symptoms of neuropathy (e.g., pain, burning, numbness) and vascular disease (e.g., leg fatigue, claudication). **B**

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Foot Care (continued)

12.27 Initial screening for peripheral artery disease (PAD) should include assessment of lower-extremity pulses, capillary refill time, rubor on dependency, pallor on elevation, and venous filling time. Individuals with a history of leg fatigue, claudication, and rest pain relieved with dependency or decreased or absent pedal pulses should be referred for ankle-brachial index with toe pressures and for further vascular assessment as appropriate. **B**

12.28 An interprofessional approach facilitated by a podiatrist in conjunction with other appropriate team members is recommended for individuals with foot ulcers and high-risk feet (e.g., those on dialysis, those with Charcot foot, those with a history of prior ulcers or amputation, and those with PAD). **B**

12.29 Refer individuals who smoke and have a history of prior lower-extremity complications, loss of protective sensation, structural abnormalities, or PAD to foot care specialists for ongoing preventive care and lifelong surveillance. **B** These individuals should also be provided with information on the importance of smoking cessation and referred for counseling on smoking cessation. **A**

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Foot Care (continued)

12.30 Provide general preventive foot self-care education to all people with diabetes, including those with loss of protective sensation, on appropriate ways to examine their feet (palpation or visual inspection with an unbreakable mirror) for daily surveillance of early foot problems. **B**

12.31 The use of specialized therapeutic footwear is recommended for people with diabetes at high risk for ulceration, including those with loss of protective sensation, foot deformities, ulcers, callous formation, poor peripheral circulation, or history of amputation. **B**

12.32 For chronic diabetic foot ulcers that have failed to heal with optimal standard care alone, adjunctive treatment with randomized controlled trial–proven advanced agents should be considered (e.g., negative-pressure wound therapy, several skin substitutes, or topical oxygen therapy). **A**

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Table 12.1—International Working Group on Diabetic Foot risk stratification system and corresponding foot screening frequency

Category	Ulcer risk	Characteristics	Examination frequency*
0	Very low	No LOPS and no PAD	Annually
1	Low	LOPS or PAD	Every 6–12 months
2	Moderate	LOPS + PAD, or LOPS + foot deformity, or PAD + foot deformity	Every 3–6 months
3	High	LOPS or PAD and one or more of the following: • History of foot ulcer • Amputation (minor or major) • Kidney failure	Every 1–3 months

Adapted with permission from Schaper et al. (123). LOPS, loss of protective sensation; PAD, peripheral artery disease. *Examination frequency suggestions are based on expert opinion and person-centered requirements.

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